DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Refer to DMCH: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

May 11, 2011

Jason A. Helgerson
State Medicaid Director
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Commissioner Helgerson:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of New York State Plan Amendment (SPA) 08-27, which was submitted to provide supplemental payments to personal care service agencies, for the purpose of improving recruitment and retention of non-supervisory workers or workers with direct patient care responsibility. During our review of the SPA, CMS performed a program analysis of the corresponding services and a reimbursement analysis related to the services impacted by the provisions of 08-27. This analysis revealed coverage issues that will require additional information and revisions to the State Plan through a corrective action plan.

Section 1902 of the Social Security Act (the Act) requires that State have a State plan for medical assistance that meets certain federal requirements that set out a framework for the State program. Implementing regulations at 42 CFR 430.10 require that the State plan be a comprehensive written statement containing all information necessary for CMS to determine whether the plan can be approved as a basis for Federal Financial participation (FFP) in the State program. In addition, section 1902(a)(30(A) of the Act requires that States have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy, and quality of care. To be comprehensive, payment methodologies should be understandable, clear and unambiguous. In addition, because the plan is the basis for FFP, it is important that the plan language provide an auditable basis to determine whether payment is appropriate.

In order to comply with the above mentioned statutory and regulatory provisions, the State must amend its approved State plan to include information to comprehensively describe the services and the payment rates and methodologies for those services. To this end, CMS welcomes the opportunity to work with you and your staff to discuss options for resolving the concerns outlined below.

The following corresponding coverage issues have been identified for 08-27.

1. New York should clarify how the nutritional and environmental support functions meet the definition for personal care services in 42 CFR 440.167 as supplemented by State Medicaid Manual, section 4480.

2. The SPA references two levels of personal care services in the 4.19-B pages but does not include a coverage description for these levels. It is difficult to determine whether the State is operating its personal care program as required by 1905(a). Please provide descriptions of each level of service including which services listed on the coverage pages constitute Levels I and II. The lack of coverage detail regarding these levels also makes it difficult to determine if this service is provided consistently with comparability requirements. 42 CFR 440.240 indicates that services must be equal in amount, duration and scope.

3. Are there any differences between a shared aide and an individual aide, or do they have the same responsibilities? Please include minimum provider qualifications in the plan.

4. The 4.19-B Page 6(a)(i)(2) references two distinct personal care service programs, adult home and enriched housing. The programs are not defined in the 3.1a and 3.1b pages. The State should provide descriptions, definitions, qualifications and whether each program provides level I and II services.

The first 3 issues above have already been included in the companion letter that was issued to New York as part of the processing action for New York SPA 10-38; they are repeated here to indicate they also are germane to SPA 08-27, and the State should provide respond to them as part of their response to the 10-38 companion letter. The last issue is new and specifically is for SPA 08-27 and should be addressed by the State at this time.

Within 90 days of the date of this letter, the State is required to submit one or more State plan amendments that resolve the issues, or a corrective action plan to resolve the issues, whichever is appropriate. During the 90-day period, CMS is happy to provide any technical assistance that the State may require to comply with the requirements of this letter. State plans that are not in compliance with the requirements outlined above are grounds for initiating a formal compliance process.

If you have any questions or wish to discuss this SPA further, please contact Ricardo Holligan or Shing Jew of this office. Mr. Holligan may be reached at (212) 616-2424, and Mr. Jew's telephone number is (212) 616-2426.

Sincerely,

/s/

Michael J. Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health

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